

Health Information Technology Policy Committee Summary of the April 13, 2011, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 22nd meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting being conducted with the opportunity for public comment, and that a transcript would be made available on the ONC Web site. She asked Committee members to introduce themselves, and turned the meeting over to Farzad Mostashari, the newly appointed National Coordinator for Health Information Technology and newly appointed HITPC Chair.

2. Opening Remarks

Mostashari lauded David Blumenthal, the previous National Coordinator for Health Information Technology, for his support and leadership in helping to set the Health Information Technology for Economic and Clinical Health Act (HITECH) agenda and move the field forward.

Mostashari explained that the ONC and HITPC will continue to work with the market and to tap into the innovation and energy of the private sector and make every effort to gain a better understanding of what is happening in the industry and in the market. He also noted the importance of continuing to watch out for the “little guy” in these efforts.

Mostashari outlined three areas of renewed emphasis for the ONC and HITPC:

- Moving into an intense implementation and execution phase, with continual improvements in terms of implementation programs.
- Putting the patients and their interests at the center of these activities, and giving greater consideration to the consumer eHealth market.
- Focusing on outcomes—the framework for meaningful use around higher quality care, safer and more efficient care, increased care coordination, patient engagement, etc.

In concluding his opening remarks, Mostashari welcomed and introduced new Committee member Josh Sharfstein, who is the Secretary of Health and Mental Hygiene for the State of Maryland.

3. Review of the Agenda

HITPC Vice Chair Paul Tang also acknowledged Blumenthal's leadership and acknowledged his leadership of the ONC and role in jump-starting HIT adoption and use. He also noted that Mostashari's vision in terms of where the country is headed with regard to HIT support is tremendously inspiring. After reviewing the day's agenda, Tang introduced Peter Lee of the Office of Health Reform, Department of Health and Human Services (HHS).

4. National Quality Strategy

Lee opened his presentation by noting that the HITPC serves as a model in many ways for the best public/private partnerships, which are critical in moving health care into the future. The issues related to meaningful use that have been discussed and developed by the Committee are incredibly important.

He noted that the National Quality Strategy was launched on the day before this meeting; HITPC members were provided with a copy of the report. Lee reminded the group that the Affordable Care Act called upon HHS to work with the private sector to develop a National Quality Strategy. The Affordable Care Act called on the secretary to engage the private sector in developing a strategy, and over 6 months HHS facilitated a discussion that featured a large amount of public comment and engagement. Comments from more than 150 groups were considered as part of this process.

The National Quality Strategy is structured with three overarching aims: (1) better care, (2) healthy people/healthy communities, and (3) affordable care. Lee emphasized that aim related to making care affordable is not geared towards reducing Medicare spending or saving states' money. This aim is to reduce the cost of quality healthcare for individuals, families, employers, and government (both state and federal). These three aims underlie a series of six priority areas in the National Quality Strategy:

- Making care safer by reducing harm caused in the delivery of care
- Ensuring that each person and family are engaged as partners in their care
- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These six priority areas are anchored in a series of 10 principles. Lee discussed three of these principles: one relating to the patient-centeredness of this work; one addressing the need for

national standardization; and one emphasizing the need for alignment within and across the government, between the federal government and the states, and with the private sector.

Lee noted that HHS recently announced the launch of a new initiative called the Partnership for Patients. This initiative, a public-private partnership, has identified a national priority around making care safer. To address this priority, two specific goals were identified: (1) reduce preventable hospital-acquired conditions by 40% in the next 3 years, and (2) reducing readmissions by 20% in the next 3 years. Lee provided examples of using the National Quality Strategy as a guide for reaching these goals, emphasizing the important roles of meaningful use and HIT.

Lee concluded his remarks by explaining that the National Quality Strategy identifies potential measures that can be used. One of the challenges facing the HITPC is that these measures in many cases have elements already built into meaningful use standards, while others do not. Issues for Committee consideration include how meaningful use plays into information that is collected and reflects care coordination, and factors that affect or reflect affordability.

Discussion

- David Lansky noted that there are many places where the National Quality Strategy intersects with HITPC work, particularly with regard to Stage 2 meaningful use requirements. He asked what the government can do to broadly stimulate vendor and implementer participation more aggressively to help generate data used for patient safety and other applications. Multiple forms of leverage are needed to accelerate this part of the agenda so that the data infrastructure is more than the fragmented separate providers with modest electronic health record (EHR) systems in their practice that contribute to this community data source.
- Lee noted his appreciation for the HITPC's work both in terms of framing meaningful use and in terms of serving as an important source of information and guidance across the federal government. He encouraged Committee members to provide comments on the National Quality Strategy and pointed to the need to aggressively align across federal programs and the private sector. Having the HITPC continue to develop robust and feasible standards is important, as is engaging with private health plans and states to align in terms of payments. Currently, most of the payment incentives that relate to meaningful use have been federal and most of the private sector has aligned around other issues.
- In response to a question from Paul Tang, Lee explained that in a number of areas, HHS is looking very closely at how to sponsor and support development measures. The Partnership for Patients initiative is an example of a situation in which the government cannot test and assess without better measures. He noted that a suite of 65 measures has been made available for public comment in the accountable care organization proposed regulations. These measures are aligned with meaningful use and across Centers for Medicare and Medicaid Services' (CMS) programs in terms of consistency with hospital measures in one case and physician quality measures in others.

- Larry Wolf agreed with the emphasis being placed on alignment, and suggested another key word—“parsimony”—as being critical to this work. Just because a measure is put in place does not mean that reporting on that measure has to be required. It is useful to carefully consider the role of HIT and meaningful use, and ensuring that the right infrastructures and technologies are in place, so that these measures can be reported. However, the entire list of measures does not necessarily need to be required as part of meaningful use. Wolf suggested that moving forward, building capability should be emphasized, perhaps more so than focusing on specific measures.
- Wolf also expressed enthusiasm for the inclusion of functional status in Lee’s report. Functional status is an attempt to formalize what a person’s life is like—this is an outcome that is often lost among lab results, height and weight measurements, etc.
- Christine Bechtel noted that there is a great deal of alignment between the priorities outlined in the National Quality Strategy and expressed hope that they can be crosswalked to Stage 1 measures as well as the measures being considered for Stage 2. She expressed having difficulty seeing the path forward for health care goals such as cardiovascular disease and suggested that the country needs a set of health care goals for the next 5 years or other time period that are specific to areas such as diabetes, smoking cessation, and heart disease. Meaningful use could be used as a lever to generate data and enhance provider participation.
- Lee noted that there are a number of national goals that have been developed, such as Healthy People 2010. The challenge is developing or identifying the appropriate measures for each of the priorities.
- Neil Calman asked about developing measures and tying them to public health goals, and pointed to the need to connect the work of providers to public health goals. Lee reminded the Committee that the National Quality Strategy addresses population health and that a more comprehensive national prevention strategy is expected to be released in the coming months.

Following this discussion, Paul Tang asked for a motion to approve the minutes of the previous HITPC meeting, held on March 2, 2011.

Action Item #1: Minutes from the March, 2011, HITPC meeting were approved by consensus.

5. Meaningful Use Workgroup—Stage 2 Update and Discussion

Meaningful Use Workgroup Co-Chairs Paul Tang and George Hripcsak provided Committee members with an overview of the Workgroup’s recent activities. Tang reminded the group that the Workgroup held a number of hearings on Stage 2 in 2010. These hearings involved testimony from specialists, smaller practices, hospitals, and others, and dealt with state issues, health care disparities, patient and family engagement, population and public health, and care coordination. The Meaningful Use Workgroup will be presenting a revised set of Stage 2 meaningful use recommendations to the Committee at its May 11, 2011, meeting. Final recommendations are expected to be submitted to the HITPC for approval at the June 8, 2011, meeting.

Hripacsak noted that on May 13, the Workgroup will convene a hearing to more fully engage specialists in meaningful use. The hearing will include the following panels: (1) care coordination among specialists, primary care, care management, and patients; (2) EHR support of specialists in patient care and clinical decision support (CDS); (3) population data, including registries; and (4) experience from the field.

Tang then briefed the Committee on HITECH statutory constraints, noting that there are time constraints framed within the reality of a health system that is not delivering the desired quality of care and is not affordable. He explained that through HITECH, the Medicare incentives are front loaded and diminish over time. There are no further incentives for those who are not meaningful users by 2014 under Medicare. In terms of penalties, those hospitals and eligible providers (EPs) who are not meaningful use providers by 2015 will start to see a decrease in Medicare payments. The criteria for qualifying as a meaningful user can be raised by HHS beyond 2015.

In response to the Request for Comments (RFC), 422 organizations submitted comments—Tang reported that the existing objectives are generally supported, and there was strong support for new objectives such as electronic clinical progress notes, patient-provider secure messaging, and recording patient preferences for communications. Mixed support was seen for other new objectives (e.g., advanced directives for EPs, longitudinal care plan). Concerns about the new objectives generally relate to the clarity of definitions/expectations or the timeline for developing and implementing new functionality. Specific HITPC questions were addressed in the RFC, with there being strong support for the group reporting option and for consideration of an alternative (outcomes oriented) option for demonstrating meaningful use. The importance of incorporating patient-reported data and strategies for segmenting different types of patient-reported data also were noted.

With regard to timing, some responders to the RFC support the current timeline (mostly consumers/purchasers, health plans, disease management organizations), while others (e.g., hospitals, physicians, EHR vendors) propose lengthening the timeline. The Meaningful Use Workgroup developed a series of illustrative timing options for Stage 2:

- Option 1: Maintain the current timeline and 1-year reporting period.
- Option 2: Maintain the current timeline and permit a 90-day reporting period (gain up to 9 months delay).
- Option 3: Delay the transition from Stage 1 to Stage 2 by 1 year (providers could get third-year payment for meeting Stage 1 expectations).
- Option 4: A phase-in approach that separates existing from new functionalities
 - 2013: Stage 2a using existing certified EHR functions with all core objectives, increased performance thresholds, and new quality measures
 - 2014: Stage 2b objectives requiring new EHR functionalities take effect.

Discussion

- Tony Trenkle noted that CMS is bringing up attestation and providers will begin to attest starting this month. Over the next several months, lessons will be learned on how this experience is playing out and that may have some impact on some of the timing decisions. He also reminded the group of the importance of taking into account other major changes to provider work that are occurring (e.g., Affordable Care Act, ICD-10, etc.).
- Judy Faulkner noted that in addition to developing software for organizations to install, vendors must support those customers, making it extremely difficult in terms of prioritizing who to assist first.
- Connie Delaney emphasized the need to continue listening to the voices of the consumers and purchasers. She noted that she supports the first timing option to keep moving forward while developing an option for EHR support.
- David Lansky commented that from the implementation experience side, the primary question is, what is the risk of non-participation in the program if the current timeline remains? Discussions on the President's Council of Advisors on Science and Technology (PCAST) report have heightened the realization that there will be continuing innovation in the data platforms and the models used to capture and transmit data. Lansky expressed concern about allowing the current engineering and technology platforms and the difficulty of making upgrades and revisions and distributing them to be the gatekeeper of progress on national priorities.
- Lansky also noted that it is difficult to see an effective way to stay the course on the new innovations in payment and health reform unless progress is made on patient engagement and care coordination implementation supports.
- Tang characterized the phase-in timing option as particularly difficult. The current process is already very complicated and the attestation is already very complicated—adding another component makes it even more so. Industry will be facing a transition to ICD-10 in October 2013, which will put an additional strain on vendors and providers. He suggested reducing the scope for Stage 2, and implementing a timeline similar to the 2a option in the phase-in approach. Tang also noted that changes in workflow should be considered when evaluating the proposed timelines.
- Marc Probst commented that one positive unintended consequence of the meaningful use process is that physicians, hospitals, and vendors are generally aligned and proposing the same thing. He also pointed to the benefit of aligning the quality measures with ICD-10. Probst noted that his preference in terms of timing options would be a combination of the second and third options.
- Gayle Harrell explained that there is an opportunity in Stage 2 to allow people to catch up. Her preference in terms of the timing options is either a combination of options 2 and 3 or

option 3. Delaying the transition from Stage 1 to Stage 2 would allow for a period of evaluation.

- Christine Bechtel pointed out that the timeline considerations have to be balanced with what the criteria are likely to be. There is a need to understand more about experience from the field, and for a more in-depth analysis of exactly which criteria it appears the Workgroup might recommend or which part of current EHR systems are already certified and which are not. Bechtel also pointed out that not only does provider workflow need to be taken into consideration, so does patient workflow.
- Larry Wolf encouraged learning from Stage 1 and noted that early feedback will be available in the coming months. He also reminded the Committee that Stage 3 is looming and suggested that consideration for Stage 3 be given now and framed within the context of what is occurring in Stage 2, to avoid having the same discussions in 2 years.
- David Bates pointed to the need for additional decision support in Stage 2.
- Farzad Mostashari asked about the entrance criteria for those entering during Stage 2. George Hripcsak cautioned against inadvertently incentivizing organizations to not adopt on the basis of having more time and delaying their penalty phase.
- Mostashari also commented that the notion of exchanging information and addressing the health reform needs of care coordination is new functionality for virtually every EHR. This represents a significant challenge on both the vendor side and the adoption side. He also asked if it would be appropriate to focus meaningful use to be the tools and behaviors one needs to succeed in any system that rewards more coordinated, higher quality, safer care?
- Neil Calman noted that the Committee has somewhat moved away from the perspective of managing populations in considering a provider-focused vision of health care. He suggested considering what would be needed to develop a coordinated, integrated system of care that improves quality and reduces cost, and comparing this to the current discussions on meaningful use to see if there are areas where the focus could change.
- In moving forward with Stage 2, Wolf emphasized the importance of revisiting standards and strengthening the recommendation that “a standard” means one. If agreement cannot be reached on one standard, there should not be a recommendation or requirement for one until that agreement is reached.

6. PCAST Report Workgroup Update

PCAST Report Workgroup Chair Paul Eggerman reported that the Workgroup has completed its work. He reminded the group that the PCAST Report was issued on December 8, 2011, and was read and accepted by President Obama. The Workgroup was charged with: (1) assisting ONC in synthesizing and analyzing the public feedback to the Report, (2) discussing the implications of the Report on ONC’s strategies, (3) assessing the impact on ONC’s programs, and (4) evaluating the recommendations in terms of their impact on the ONC strategic framework. Eggerman noted

that the Workgroup was not charged with judging the Report. The Workgroup's comments should not be interpreted as either endorsing or rejecting the technology or endorsing or rejecting any policies that might be inferred from the PCAST Report. He then presented the list of PCAST Report Workgroup members and acknowledged individuals from the ONC and PCAST who provided assistance.

The PCAST Report included three fundamental directions:

- Accelerate progress toward a robust exchange of health information.
- Establish a new exchange architecture with a universal exchange language (UEL) and interlinked search capabilities coupled with strong privacy and security safeguards. The exchange architecture will enable clinicians and patients to assemble a patient's data across organizational boundaries and facilitate population health.
- Establish an evolutionary transition path from existing installations to the new exchange architecture.

In its report, PCAST Report Workgroup members explained the new exchange architecture both from the perspective of users using this system and also provided a technical description. The Workgroup also took into account public feedback, which impacted the work related to understanding the architecture. The Workgroup included two task forces, one focusing on policy issues, the other addressing issues related to implementation of the technology. The Workgroup highlighted the top three policy issues, which are: (1) privacy and security; (2) multi-patient, multi-entity analyses; and (3) governance.

PCAST Report Workgroup Vice Chair William Stead noted that the PCAST Report included directional statements, but it did not actually provide a specific recommendation about a technical implementation. The Workgroup identified alternative technical implementations by starting to define four use cases (push by patient between two points, simple search, complex search, de-identified aggregate data search and retrieval). Based on those use cases, the Workgroup created a table that illustrates three implementation approaches side by side, which Stead presented to the Committee. The Workgroup also considered Meaningful Use Workgroup activities and found no conflicts between the PCAST Report and Meaningful Use Workgroup efforts.

The PCAST Report Workgroup developed three summary statements:

- The PCAST Report describes a national use of advanced technology. It provides a compelling vision for how that technology could be beneficially used as an important aspect of the learning health system.
- There are major policy and operational feasibility concerns with the proposed technology.
- Aggressive and rapid progress is possible only with an incremental test-bed approach. Large operational tests are needed that resolve the policy and feasibility concerns.

Egerman commented that one challenge facing the Workgroup was taking the PCAST Report translating it into the reality of meaningful use Stages 2 and 3. Egerman presented the Workgroup's report to the Committee to consider for acceptance and subsequent submittal to the National Coordinator. Farzad Mostashari thanked Egerman, Stead, and the other members of the PCAST Workgroup and congratulated them for meeting their charge.

Discussion

- Egerman explained that the PCAST Report Workgroup was not proposing a recommendation to the Committee. Rather, it was providing statements of possibilities (e.g., indicating that there could be incremental test beds), an explanation of what the report does, and a number of alternatives. Stead reminded the Committee that the Workgroup was charged not to produce recommendations.
- David Bates asked about operational feasibility concerns. Egerman explained that these concerns can be found in the discussion related to public comments on the PCAST Report. Some of the feasibility issues related to the suggestion of a more atomic approach to information exchange. This suggestion created a series of operational feasibility questions.
- Larry Wolf commented that one issue that is implicit in the Report but not overly discussed is the notion of push versus pull use of information. The HITPC tends to focus on the push transactions (e.g., I have some information about a patient and I want to pass it on to the next provider). However, often in the course of care, questions arise about what happened in the past, and this area has not been well addressed.
- David Lansky asked if the suggested implementation test were to be deployed, with a patient-centric implementation application, whether there would likely be a set of consequences for the clinical workflow and the care delivery system. Or, is this a segmented method of beginning the implementation process, which insulates the clinical infrastructure from this new experiment? If the vendor does the engineering to meta tag the granular data elements to support the patient export function, does that have implications for how that vendor would then in turn support clinical applications because the data has now been managed internally in a new way? Egerman explained that the way it was suggested in the Workgroup's letter is that our letter is that the vendor would not need to do something special to each data element. It is not a change to how the data is collected, so there is not a clinical impact.
- In response to a question, Egerman explained that from a user perspective, the PCAST Report is suggesting an Internet-style approach to doing searches. It represents a vision of being able to search all EHR databases as if they were one all over the country and find out information on a single patient.
- Neil Calman asked if the PCAST Report is recommending a system that built from the recipient need point of view and a clinical encounter, allowing people to first see something in a very basic and summarized way, but giving them the capability of drilling down continuing to mine more information as needed in the course of a clinical encounter. Both

Egerman and Stead indicated that this was the case. Calman commented that this provides tremendous additional value to exchange.

- Judy Faulkner expressed support for the test bed approach. She noted the need to determine where there is overlap between what is already being done and what health information exchanges (HIEs) are doing. Faulkner also indicated that there is a need to be cautious about an apparent conflict of interest. Some blogs have noted that the primary spokesperson for PCAST has products that would benefit tremendously by this.
- Egerman suggested that the ONC and HHS own this architecture, not PCAST, and call it the New Exchange Architecture in lieu of the PCAST Architecture.

Following this discussion, Mostashari asked for and received a motion to accept the PCAST Report Workgroup's letter. The motion was seconded and the Committee accepted the letter.

Action Item #2: The Committee accepted the letter from the PCAST Report Workgroup.

7. Federal Health IT Strategic Plan Overview

Jodi Daniel of ONC noted that the ONC published the Federal Health IT Strategic Plan on March 25, 2011. The Plan is important guiding federal efforts and investments in HIT over the next several years. The Office was mandated by HITECH to revise the strategic plan, which accounts for the rapidly changing landscape of HIT and HIT policy as well as HITECH and the Affordable Care Act. In characterizing the scope, Daniel explained that the Plan represents ONC's strategy for realizing Congress and the Administration's HIT agenda.

Daniel explained that the HHS strategic plan has five goals, one of which is to transform health care. Within this goal is a specific objective of transforming health care related to HIT. In essence, the Federal Health IT Strategic Plan examines tools to transform health care and considers how HIT can be used to improve care coordination, patient engagement, etc. Daniel noted that starting with focusing on better technology is how we can get to better information, and therefore better health and transformed health care.

Daniel described the strategic planning process, which included public comment periods as well as input from stakeholders and federal partners. The plan features five goals that are linked to various objectives and strategies:

- Achieve adoption and information exchange through meaningful use of HIT.
- Improve care, improve population health, and reduce health care costs through the use of HIT.
- Inspire confidence and trust in HIT.
- Empower individuals with HIT to improve their health and the health care system.

- Achieve rapid learning and technological advancement.

Daniel then presented a slide highlighting how the strategic framework developed by the HITPC maps to the Federal Health IT Strategic Plan. She also noted areas where the Plan aligns with the National Quality Strategy. In concluding her remarks, she noted that the public comment period for the Federal Health IT Strategic Plan is open through April 22, 2011. HITPC members were invited to provide comments online. The final Plan will be released in early June 2011.

Discussion

- Deven McGraw cautioned against “siloing” meaningful use and achieving it as though it is separate from other programs that are aimed at achieving goal two (improvement in care outcomes). Daniel agreed, noting that the same concept holds true for privacy and security, which is necessary to seed the longer term vision.
- Seth Pazinski of ONC clarified that the document is not an ONC plan, but a federal plan, and broad enough to encompass everything the government is doing.

8. Privacy and Security Tiger Team Recommendations

Privacy and Security Tiger Team Chair Deven McGraw and Co-Chair Paul Egerman presented a series of recommendations to the Committee in the areas of: (1) EHR user (provider) authentication, (2) patient portals (privacy and security), (3) Stage 2 security risk assessment, and (4) patient matching. McGraw noted that the patient matching recommendations had already been approved by the HITPC, but there is a need to send an official referral to the HIT Standards Committee (HITSC) so that it can begin the work. McGraw also noted that Committee members were provided with a recommendations document that provides additional information.

Egerman then presented the recommendations related to EHR user authentication as follows:

- Organizations that are seeking to exchange information as part of the NwHIN should be required to adopt baseline user authentication policies that require more than just user name and password for remote access.
 - At least two factors should be required.
 - Remote access is defined as access over a public network like the Internet.
 - ONC should seek public comment on this issue.
- Organizations and entities can adopt more stringent requirements.
- For more sensitive, higher risk transactions, an additional authentication of greater strength may be required.
 - Similar to the DEA policy covering prescribing controlled substances.
 - Additional work may be needed by the Policy Committee and ONC to identify the potential use cases that might require authentication above the baseline requirement.
- NwHIN policies should be re-assessed for consistency with other national identity efforts and technology developments.

- ONC should also work to develop and disseminate evidence about the effectiveness of various methods for authentication and reassess NwHIN policies accordingly.
- For Stage 2 of meaningful use:
 - EPs and hospitals should be required to obtain digital certificates (per previous recommendations) and the EHR certification process should test use of digital certificates for appropriate transactions.
 - EPs are required to comply with the DEA rule regarding e-prescribing of controlled substances and Stage 2 certification testing criteria for EHRs should include testing of compliance with the DEA authentication rule, which requires two-factor authentication.

McGraw then presented recommendations in the area of patient portals:

- Identity-proofing recommendations:
 - The Tiger Team supports entities making their own determinations of what is required to identity proof patients based on their own assessments of what is necessary to address the risks of inappropriate access.
 - The Tiger Team has developed a set of guiding principles to assist with identity proofing.
 - ONC should work with the National Institute of Standards and Technology (NIST) to provide guidance to providers on trusted identification methods to reflect:
 - Federal government e-identification efforts.
 - Innovations in technology.
- Authentication recommendations:
 - Providers should require at least a user name and password to authenticate patients; this requirement should be included as a Stage 2 meaningful use objective.
 - Certified EHRs should include a capability to detect and block programmatic attacks or attacks from a known but unauthorized person (e.g., auto lock-out); this requirement should be included as a Stage 2 requirement.
 - ONC should work with NIST to provide guidance to providers on trusted identification methods. This should reflect:
 - Federal government e-identification efforts.
 - Innovations in technology.
- Additional requirements for patient portals recommended by the Tiger Team for consideration as part of Stage 2 include:
 - EPs and hospitals should deploy audit trails for a patient's portal, and at least be able to provide these to patients upon request. Audit trail capability for the portal will need to be part of Stage 2 certification requirements.
 - Patient portals also should include appropriate provisions for data provenance, which is accessible to the user, both with respect to access and also upon download.
 - Patient portals should include mechanisms that ensure information in the portal can be securely downloaded to a third party authorized by the patients.

Egerman then listed the two security risk assessment recommendations as follows:

- The Tiger Team recommends that EPs and eligible hospitals continue to be required to do a security risk analysis.
- Providers and hospitals must address how they are implementing encryption functionalities for data at rest and must attest that they have done this as part of their required security risk assessment
 - Due to large number of breaches of unencrypted PHI, the Tiger Team believes that HHS should use the meaningful use criteria to help shine a spotlight on this persistent problem.
 - The Team recognizes that covered entities may reasonably use different approaches for protecting data at rest depending on the location, portability and immediate use of the data.

McGraw concluded the presentation by briefly reviewing the patient matching recommendations that were previously accepted by the HITPC and involve a list of activities for the HITSC.

Discussion

- Paul Tang noted that when HIE becomes widely available, patient data will be flowing—he asked whether a potential threat would be wherever the organization accesses the information at the point where they have the least amount of identity proofing. Egerman responded by first defining a patient portal, which in this context is the ability of a patient to view their own record. At this stage, patients have minimum opportunity to change anything. He explained that the Tiger Team wanted to encourage patient engagement constantly in this process, and that a significant challenge involves balancing utility and risk.
- Deven McGraw noted that there are entities already responsible for breaches, and it is up to them to decide how they are going to deploy this in a way that keeps that information safe. McGraw emphasized that access is limited only to what the entity has made available for the patient to see. Tang noted that in the HIE world, there are many ways that data from many sources are being made available to an individual claiming to be who that person says they are.
- McGraw noted that there is already a baseline standard of reasonable and appropriate safeguards that the Health Insurance Portability and Accountability Act (HIPAA) Security Rule provides. The principles presented by the Tiger Team could be used to layer additional security on top of this, but if the risk tolerance level is so high that the bar too high and people cannot use it, this will not meet the objectives.
- Neil Calman commented that if one is committed to exchange, participants cannot set higher levels of authentication than everybody else because it is only as strong as the person who is accessing it. If one group is giving a person access and the person only requires two-factor authentication but is accessing the group's EHR records that require three-factor authentication for their own providers, what does that mean? Allowing people to build

higher levels of security or higher levels of policies interferes with the future vision. For this reason, efforts are being made to create standards that will allow free-flowing access across these barriers that meets a certain level of authentication.

- McGraw clarified that the Tiger Team's recommendations to date have assumed that the model of exchange that exists today largely on paper is being moved into a digital format. Everyone has responsibility for the data that they have stewardship over, that is in their control, that is in their EHRs, which gives them a certain amount of authority about how they address role-based access.
- Calman asked about patient choice in terms of level of concern related to the balance between ease of access and the security of patient records. He asked if it would be possible to build in some type of recommendation that allows for or suggests that there should be patient choice in the level of security that their information has. McGraw noted that if this option wasn't included in the guidelines, it was intended to be included, and the Tiger Team will add it. Tang cautioned that providers can only offer this if their system has the capability to do so.
- Larry Wolf noted that many organizations provide a remote access technology that then is applied to many applications. The security they provide as an organization for remote access is not embedded in any one application, but, in fact, is a platform that is made generally available and then based on the user, different applications are included and might require a single sign-on, so they do not have to re-authenticate. Wolf also noted that where there are HIPAA requirements, efforts should be made to help people understand not just that there is a requirement, but that there might actually be industry best practices in place.
- McGraw noted that in the Tiger Team's letter, there is a suggested that the HITSC provide recommendations on what would be factors for two-factor authentication. In the letter, concerns are raised about the balance between ease of access of very important information that sometimes is extremely time sensitive to the important security protections for remote access. The Tiger Team also suggested obtaining public comment on these issues.

Action Item #3: The Committee voted to approve the recommendations from the Privacy and Security Tiger Team.

9. Information Exchange Workgroup Recommendations

Information Exchange Workgroup Chair Micky Tripathi provided the Committee with a brief update on the group's activities since the last HITPC meeting. At the last meeting, the Workgroup presented a series of recommendations related to individual-level provider directories (ILPDs), which followed on from recommendations that were made and approved by the HITPC in December related to the entity-level provider directories (ELPDs). The HITPC directed the Workgroup to streamline the ILPD recommendations, which are being revised and will be brought before the Committee at its May 11, 2011, meeting.

Tripathi also noted that the Workgroup has been engaged in considering the meaningful use Stage 2 and Stage 3 recommendations and is conducting a detailed line-by-line commentary on

the Stage 2 recommendations that the Meaningful Use Workgroup released for public comment earlier this year. The Information Exchange Workgroup has already submitted one letter to the Meaningful Use Workgroup that addresses a number of the recommendations. The Information Exchange Workgroup supports a number of the recommendations as written—the Workgroup also suggests being more or less aggressive with regard to other recommendations from the Meaningful Use Workgroup. The Information Exchange Workgroup is drafting a second letter that addresses the remaining recommendations that the Meaningful Use Workgroup released to the public and will be submitting that letter in the coming weeks.

The Information Exchange also is reaching out to the Meaningful Use Workgroup to determine which areas the Meaningful Use Workgroup would like input on. There are a number of Stage 2 and Stage 3 issues for which the Meaningful Use Workgroup anticipates obtaining comment from the Information Exchange Workgroup. These include how to move beyond push transactions, query response types of exchange, data aggregation for quality measurement and population health, etc.

10. Enrollment Workgroup Update

Enrollment Workgroup Co-Chair Sam Karp reminded the Committee that the Workgroup provided 10 recommendations to the HITPC and HITSC that were submitted to the HHS Secretary in early September 2010. The Secretary accepted these recommendations with minor changes, and they have become part of the requirements and guidance that CMS is providing to the states with respect to the development of health insurance exchanges that are being developed in the states. The Enrollment Workgroup still has Three Tiger teams working on consumer engagement issues, business rules, and privacy and security, and it is hoped that the Tiger Teams will complete their work in the coming months and bring recommendations forward.

Karp explained that the Enrollment Workgroup was asked by CMS to provide feedback on a set of questions related to the utility of a federal service that would carry out verifications. He noted that the Affordable Care Act requires that eligibility be electronically verified in three specific areas: (1) that the Social Security Administration (SSA) verify electronically that the applicant is a U.S. citizen, (2) that the Internal Revenue Service (IRS) verify income, and (3) that the Department of Homeland Security (DHS) verify immigration status. The Enrollment Workgroup heard public testimony from representatives of the SSA, IRS, and DHS to assess where they were in terms of meeting these requirements. The Workgroup was assured by each of these agencies that they had the ability to provide electronic verification in real time.

As a result of the public testimony, the Workgroup included in its initial recommendations two specific items with respect to verification. One was that in performing these verification assessments, there be a standardized set of Web services used. The second related to the development of a “federal reference software model,” which CMS is now calling a “verification hub” or “federal hub services.” The was that rather each state having to develop its own verification service and connect separately to the SSA, IRS and DHS, if this were done in a more standardized way it could be more efficient and most cost effective. Based on those recommendations, CMS is moving forward, at least conceptually, with this idea of a verification service.

The HITPC was provided with a letter summarizing the comments from the Tiger Teams and from the Enrollment Workgroup overall. Karp summarized the letter by indicating that the Workgroup feels that the service is consistent with the recommendations that the group previously made. The group's feeling is that a verification service that works well is likely is the most significant or single most effective thing that can be done to simplify enrollment. The Workgroup indicated in the letter that at the federal level, this hub could provide the highly desirable service of identifying one of the requirements in the Affordable Care Act—whether an individual has existing federal health insurance provided by FEHB, TRICARE, or Medicare. The letter also articulates a number of other recommendations and requests for feedback to specific questions.

Although not specifically asked to comment on the consumer relationship with the proposed hub, the Workgroup feels that at a minimum, consistent with other recommendations it made about the consumer roles, that a consumer should be able to see, use, and update/correct/appeal any information that is returned to the Exchange by this type of a federal hub for verification. Karp emphasized that the consumer should be provided with information that is understandable.

Discussion

- Larry Wolf asked if the Workgroup discussed data quality or about identity management, commenting that it seems as though the issues related to patient IDs multiply when this type of information is looked at. Karp replied that there was a great deal of discussion on these issues in the Workgroup. One part of the Workgroup's initial recommendations related to the need to standardize data elements using the National Information Exchange Model. There is an ongoing ONC project to develop NIEM standards for specific data elements.
- Wolf emphasized the need to work with individuals in resolving any problems that occur given that the likelihood of identity problems is not trivial and the implications are very large. Karp agreed, noting that in most cases today verification is done through paper documents and handled individually. Reducing that number takes a tremendous burden off the system, which hopefully will allow the system to be able to focus on that smaller percentage of people who will need to be worked with individually.
- David Lansky asked about issues related to consent, access, re-use, etc., once the hub and other programs come online. He also asked about issues tied to accessing current income verification, state-level databases, or household member information in addition to the individual patient or enrollee information.
- Karp indicated that there are a number of policy issues that come into play. For example, at what point in the process is the applicant asked for her or his consent before the data elements are used to verify income or citizenship? CMS is examining this issue at present. Another policy issue is the limitation of use of this data, particularly data from DHS. Karp also explained that in terms of the additional data sources mentioned by Lansky, the Workgroup's letter identifies these and others that would provide more current information about an individual or a family's income.

- Lansky asked if the Workgroup was planning to develop another letter that would more specifically outline a policy framework for the hub functionality. Karp indicated that the Workgroup has discussed this issue but has not considered another letter. He explained that the Workgroup was structured more like a technical workgroup than a policy workgroup, and was often counseled not to address policy issues during its deliberations.

Action Item #4: The Committee voted to accept and transmit the letter from the Enrollment Workgroup.

11. Certification/Adoption Workgroup Update

Certification/Adoption Workgroup Chair Mark Probst reminded the Committee that the Workgroup was asked to examine the topic of usability, and that the Workgroup was holding a hearing on the topic on April 21. The hearing will feature a panel of experts and will focus is on the overall effectiveness of EHRs as it relates to usability, understanding some of the safety issues associated with usability and the use of EHRs, and identifying compelling issues associated with usability.

The hearing will also feature a discussion on testing, specifically focusing on the issue of the type(s) of testing that can be done relative to usability or measurement and how one measures “good” usability. It is hoped that the hearing will capture both the clinician perspective as well as the patient or the family end user perspective on usability and also consider some of the disability issues associated with usability. Committee members were provided with a copy of the hearing’s agenda.

Before turning the meeting over to the public comment session, Paul Tang acknowledged the new leadership of Farzad Mostashari as National Coordinator as well as the efforts of ONC staff in supporting the HITPC’s activities. He specifically thanked Judy Sparrow for her work in helping to coordinate these efforts.

12. Public Comment

- Dan Rode of the American Health Information Management Association (AHIMA) thanked the Committee for its discussions, particularly those related to alignment. He commented that alignment is especially important today, given the meaningful use goals related to EHRs and the fact that providers are under pressure to respond to other forces, such as the introduction and implementation of ICD-10. Rode emphasized the need to consider these outside activities while moving forward, adding that AHIMA stands ready to provide any information that can be of help to the Committee.
- Robin Raiford of Allscripts commented that two-factor authentication is in use today with many EHRs and e-prescribing systems. The Ohio State Board of Pharmacy requires two-factor authentication, so any EHR vendor or e-prescribing system that sells and has clients in Ohio already has that in their system.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the March, 2011, HITPC meeting were approved by consensus.

Action Item #2: The Committee accepted the letter from the PCAST Report Workgroup.

Action Item #3: The Committee voted to approve the recommendations from the Privacy and Security Tiger Team.

Action Item #4: The Committee voted to accept and transmit the letter from the Enrollment Workgroup.